

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

OTC 8/8/10

PRINTED: 06/29/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445292	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/24/2010
NAME OF PROVIDER OR SUPPLIER BEECH TREE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 240 HOSPITAL LANE, PO BOX 300 JELICO, TN 37762	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint investigations for TN00025739; TN00025842; TN00025882; TN00025266, TN00025208 and TN00026104 were completed at Beech Tree Manor between June 21, 2010, and June 24, 2010. No deficiencies were cited under 42 CFR Part 483.13 Requirements for Long Term Care. Deficiencies were cited for #TN00025905, #TN00025919, #TN00025252, and complaint #TN00025361.	F 000	This Plan of Correction is prepared and executed because it is required by the provisions of State and Federal law and not because Beech Tree Manor agrees with allegation(s) and citation(s) listed on this Statement of Deficiencies. Beech Tree Manor maintains that the alleged deficiencies do not individually or collectively constitute substandard care or jeopardize the health and safety of the residents; nor are they of such character so as to limit our capability to render adequate care. This Plan of Correction shall also serve as the facility's written Credible Allegation of Compliance.	
F 223 SS=D	483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on medical record review, policy review, observation and interview, the facility failed to prevent abuse for two residents (#5 and #6), of fourteen residents reviewed. The findings included: Resident #5 was admitted to the facility on May 8, 1998, with diagnosis of Seizures, Mental Retardation, Psychosis with Depression and Anxiety. Medical record review of the Minimum Data Set dated June 2, 2010, revealed the resident had both short and long term memory	F 223	F 223 Residents #5 and #6 will be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion per the facility's Abuse Policy and Personal Electronic Device Policy. All residents will be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion per the facility's Abuse Policy and Personal Electronic Device Policy. Facility staff will be inserviced by the Director of Nursing or the Staff Development Coordinator about the facility's Abuse Policy including reporting of suspected abuse and the facility's Personal Electronic Device Policy. Any allegation of abuse will be	7/17/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Charles W. Wheeler, NHA

TITLE

Administrator

(X6) DATE

7-9-10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 223	<p>Continued From page 1</p> <p>deficits and the resident's cognitive status was "moderately impaired." Further review revealed the resident was totally dependent in bathing.</p> <p>Record review of the facility's statement from LPN #3 (licensed practical nurse) dated May 26, 2010, revealed " ...she had heard a rumor from a CNA (certified nurse assistant) that there was a video on a cell phone of resident #5 in the whirlpool tub...LPN #3 stated she did not remember who had told her about it, but stated that she thought she had heard about it sometime during the weekend prior to today ..."</p> <p>Record review of the facility's statement from LPN #4 dated May 27, 2010, revealed " ...2 CNAs working with her had reported seeing the video of resident #5 in the whirlpool tub. The DON instructed LPN #4 to have both CNAs come see the DON the following morning to discuss this situation further."</p> <p>Record review of the facility's statement from CNA #3 dated May 28, 2010, revealed " ...sometime in the last couple of weeks she had seen a video taped recording of resident #5 in the whirlpool bath tub. The recording was on CNA #4's cell phone. CNA #3 stated that she told CNA #4 she should not have that on her phone and reported it to the charge nurse..."</p> <p>Record review of the facility's statement from CNA #6 dated May 28, 2010, revealed " ...sometime within the past couple of months, she had seen a video taped recording on a cell phone of resident #5 in the whirlpool tub. She did not remember whose phone it was or who had seen the video..."</p>	F 223	<p>discussed in the facility's A.M. Meeting by the administrative staff to include the Administrator, Director of Nursing, Assistant Director of Nursing, MDS/Care Plan Nurse, Social Worker, Activity Director, and Dietary Manager. Any allegation of abuse will be discussed and reviewed in the monthly Quality Assurance Committee meeting to verify that the facility Abuse Policy and the Personal Electronic Device Policy is being adhered to by facility staff.</p>		

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F 223	<p>Continued From page 2</p> <p>Record review of the facility's statement from CNA #4 dated May 28, 2010, at 4:00 p.m., revealed "I took a video of ...(resident #5) in the whirlpool and showed it to ...(housekeeper #1) in housekeeping. Not very long after I joined the shower team. After showing ...(housekeeper #1) I deleted the video from my phone ..."</p> <p>Record review of the facility's statement from the DON dated May 28, 2010, revealed " ...Upon receiving ...(CNA #4) written statement regarding the recording of a resident in the whirlpool tub, it was read by the DON and Administrator. The Administrator then stated to CNA #4 that she had the option to either resign or be terminated at this time...She then left the administrator's office and was escorted from the building by the DON ..."</p> <p>Interview with CNA #3 on June 22, 2010, at 2:30 p.m., in the conference room, revealed CNA #4 had showed her the cell phone video. CNA #3 stated she thought she had seen the video sometime in the middle of April - but did not know the exact date. CNA #3 stated she immediately informed her supervisor (LPN #3) of the cell phone video. CNA #3 stated she could see resident #5 in the whirlpool tub - splashing the water - showing her breast.</p> <p>Interview with CNA #6 on June 21, 2010, at 3:15 p.m., in the conference room, revealed she saw the cell phone video of resident #5. She stated she could see the resident, however she could not see any other "body parts." She stated she could not remember when she saw the video. Additional interview with CNA #6 on June 22, 2010, at 2:00 p.m., revealed she denied being in the shower room with CNA #4 when she was taking the cell phone video of resident #5.</p>	F 223			

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F 223	Continued From page 3 Interview with Housekeeper #1 on June 22, 2010, at 2:00 p.m., in the conference room, revealed she never did see the cell phone video, but she had heard about it. Interview with LPN #3 on June 24, 2010, at 10:00 a.m., by phone, revealed she could not recall the specific date she was informed of the existence of the cell phone video of resident #5. Further interview revealed LPN #3 had never seen the cell phone video. Interview with CNA #4 (the accused) on June 21, 2010, at 10:30 a.m., by telephone, revealed she did use her cell phone to video tape resident #5 in the whirlpool tub. She stated that resident #5 could be seen "from the neck up." She stated she showed it to resident #5 and to housekeeper #1 and then deleted the video from the phone. Observation of the whirlpool tub with CNA #7, on June 23, 2010, at 2:00 p.m., revealed the water would cover a resident's chest. Interview with CNA #7, at that time, in the shower room revealed "anyone resident that I have assisted with a whirlpool bath - the water reaches above the breast." Review of the facility's "Personal Electronic Devices" policy revealed " ...the use of personal electronic devices is allowed only in designated employee break areas or personal vehicles ...the use of camera functions and/or other audio or video recording functions commonly found on personal electronic devices is not allowed at any time on company property. The use of such functions will be considered a violation of employees and resident privacy ..."	F 223			

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F 223	Continued From page 4 Interview with the Director of Nurses on June 22, 2010, at 2:00 p.m., in the conference room, revealed the cell phone policy had not been enforced prior to the cell phone video incident. Interview with the Administrator on June 21, 2010, at 11:30 a.m., revealed the facility did not have any system in place to monitor possible violation of cell phone policy by employees. Review of the facility's "Abuse" policy revealed the definition of mental abuse is defined as "...but not limited to, humiliation, harassment..." Interview with the Director of Nurses on June 23, 2010, at 2:15 p.m., in the conference room, confirmed the resident's rights were not protected by the facility. Resident #6 was admitted to the facility on July 7, 1997, with diagnoses of Intermittent Explosive Disorder, Seizures, Mental Retardation, and Anxiety. Medical record review of the Minimum Data Set dated June 9, 2010, revealed the resident had both short and long term memory deficits. Further review revealed the resident's cognitive status was "moderately impaired." Further review revealed the resident had socially inappropriate behavior and resisted care. Review of the facility's statement from CNA (certified nurse assistant) #4 dated May 26, 2010, revealed " ...I was standing at the 300 hall nurse's station when one of the nurse's LPN (licensed practical nurse) #3 was arguing with ...(resident #6) ...(LPN #3) then picked up the phone and called for ...(DON) ...(LPN #3) looked at ...(resident #6) and said 'I hope they send you out	F 223			

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F 223	<p>Continued From page 5</p> <p>of here tonight'...(resident #6) said something back then...(LPN #3) said 'you should be in the nut house, that's where you need to be...'"</p> <p>Review of the facility's statement from LPN #3 (not dated) revealed "...On May 26, 2010, resident #6 was having several behaviors had redirected she kept getting out of merri-walker unassisted. Instructed her that office staff had spoke with her brother concerning finding her some place else to live she stated she didn't want to go to nut house then after several minutes she had her shoe off threatening to throw it at me. Instructed her if she threw it that someone would call the police. She stated she didn't care. I stated to her with this behavior you will have to go to nut house and you don't want that. I then called for DON to come to floor."</p> <p>Interview with Director of Nurses (DON) on June 22, 2010, at 2:10 p.m., revealed LPN #3 had reported her conduct to her and was sent home pending investigation of allegation of abuse. Further interview revealed LPN #3 was suspended for three days for violation of resident rights related to verbal abuse.</p> <p>Review of the facility's employee conference dated May 26, 2010, stated "...employee in violation of resident's rights related to verbal abuse police ...3 day suspension ..."</p> <p>Interview with LPN #3 on June 24, 2010, at 10:00 a.m., by telephone, revealed she did tell resident #6 that she "would be sent to a nut house." Further review revealed she was sent home pending investigation and received a three day suspension.</p>	F 223			

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F 223	Continued From page 6 Interview with CNA #4 on June 21, 2010, at 12:45 p.m., revealed she heard LPN #3 make rude remarks to resident #6. Further interview revealed she reported the incident to the charge nurse and the LPN was sent home pending investigation. Review of the facility's policy on "Abuse" revealed "...Verbal abuse is defined as any use of oral, written or gestured language that includes disparaging and derogatory terms to residents..." Observation of the resident on June 24, 2010, at 10:30 a.m., in the resident's room, revealed the resident dressed and in Meri-walker (ambulation aide). Interview with the resident at that time revealed she did not recall the incident. Interview with the DON on June 23, 2010, at 2:15 p.m., in the conference room, confirmed the LPN had violated resident #6's rights related to verbal abuse. C/O #TN00025905, #TN00025915	F 223			
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on medical record review, policy review,	F 226			

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F 226 Continued From page 7

observation and interview, the facility failed to immediately report allegations of abuse for two residents (#1 and #5) of fourteen residents reviewed.

The findings included:

Resident #1 was admitted to the facility on December 26, 2007, with diagnoses including Paraplegia Secondary to Motor Vehicle Accident, and Depression. Medical record review of the Minimum Data Set dated April 19, 2010, revealed the resident had no long or short term memory deficits and no cognitive impairment.

Record review of facility's statement of CNA (certified nurse assistant) #5 dated February 22, 2010, revealed "I observed ...(resident #1) sister fussing at ...(resident #1) and talking down to her. She was made - saying ...(resident #1) needed to quit calling her all hours of the night. This event took place on Thursday, February 18, 2010 ..." Further review revealed this event took place before the incident in the resident's room.

Medical record review of the Nurse's Note dated February 18, 2010, at 7:10 p.m., revealed "Resident family member ...(sister) came to nursing home. Resident and sister went into her room - then they came out and went outside day room doors and smoked - When they came back in a old man was with them. They entered room - CNAs enter room - older man came out ...(sister) came out shortly. When CNA came out of room, said resident's sister pulled her hair and was verbally abusive toward resident. Resident then came out of room - said she called the police on her sister for pulling her hair and spitting in her face and calling her names. 7:30 p.m. Police

F 226

Residents #1 and #5 will be protected from mistreatment, neglect, and abuse per the facility's Abuse Policy which includes any allegation of abuse being reported immediately to Administration. All residents will be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion per the facility's Abuse Policy. All staff will be inserviced by the Director of Nursing or the Staff Development Coordinator about the facility's Abuse Policy, including reporting of suspected abuse, and the facility's Personal Electronic Device Policy. Any allegation of abuse will be discussed in the facility's A.M. Meeting by the administrative staff to include the Administrator, Director of Nursing, Assistant Director of Nursing, MDS/Care Plan Nurse, Social Worker, Activity Director, and Dietary Manager. Any allegation of abuse will be discussed and reviewed in the monthly Quality Assurance Committee meeting to verify that the facility Abuse Policy and the Personal Electronic Device Policy is being adhered to by facility staff.

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F 226	<p>Continued From page 8</p> <p>Department came out - took resident's statement. Said if ...(sister) came back to call - and he would have paper work send to nursing home in am ..."</p> <p>Record review of facility's statement of CNA #6 dated February 19, 2010, revealed " ...(CNA #3) and myself went to ...(resident #1) room to dry her and ...(sister) was arguing, then it escalated until ...(sister) pulled ...(resident #1) hair and called her a paralyzed whore."</p> <p>Record review of facility's statement of CNA #3 (not dated) revealed "It was on Thursday night - February 18, 2010, about 7:10 p.m ...(sister) and her boyfriend came in to see ...(resident #1) ... (sister) was already mad when she came in, me and ...(CNA #6) was in ...(resident #1) room changing her and her sister came in mad, calling her vulgar names, went over to ...(resident #1) spit in her face and pulled her hair, and turned around - went to ...(resident #1) doorway and called her everything and then left ...(resident #1) told us to call the police for her, the police came out made a report and said if ...(sister) came back to call them back ..."</p> <p>Record review of the police report dated February 18, 2010, at 19:20, revealed " ...(resident #1) reported that her sister from Kentucky came to ... (facility) where she is a resident and started yelling at her then pulled her hair and then struck her two to three times then left ...(resident #1) stated that the sister lives in Kentucky and that she believes that her sister has been drinking an intoxicating beverage because of her actions ..."</p> <p>Record review of the facility's statement from the Director of Nurses (DON) dated February 19, 2010, revealed " ...sister of ...(resident #1) visited</p>	F 226			

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F 226	<p>Continued From page 9</p> <p>the facility on 2-18-10 at approximately 7:00 p.m. She went out to smoke with the visitors. They went back into resident's room. Around 7:30 p.m. ... (sister) left the room and ... (resident #1) came out and stated that her sister had pulled her hair and spit in her face ... (resident #1) stated that she had called the police ... (sister) had left the building ... Physical assessment was done times 3 shifts following the incident. Nursing staff found no injuries ... The resident and direct care staff were instructed to notify the police if her sister returned to ... (facility) ... No trespassing order taken to police department by DON ..."</p> <p>Record review of the facility's No Trespassing Order dated February 19, 2010, revealed the resident's sister was notified on February 19, 2010, that she is "not welcome" on facility's property and if the sister did trespass the local police department would be notified.</p> <p>Interview with CNA #5 on June 23, 2010, at 2:55 p.m., in the conference room, revealed she saw resident #1 and her sister before the reported incident. CNA #5 stated she saw resident #1's sister pushing resident #1 in the wheelchair down the hall. She stated at that time the sister was cussing resident #1 and calling resident #1 names. CNA #5 stated she did not notify the charge nurse of the incident and after she saw resident #1's sister cussing and calling her names - she left the area "to go have a cigarette". CNA #5 confirmed she did not protect the resident and did not immediately notify the supervisor as per the facility's abuse policy.</p> <p>Observation of resident #1 on June 21, 2010, at 11:20 a.m., revealed the resident propelling herself up and down the hallways. Interview with</p>	F 226			

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F 226	<p>Continued From page 10</p> <p>the resident at this time in the conference room, revealed she and " ...her sister had an argument". Further interview revealed the sister "pulled her hair" and called her a "paralyzed whore".</p> <p>Interview with the DON on June 23, 2010, at 2:15 p.m., in the conference room, confirmed CNA #5 did not follow the facility's abuse policy and notify the charge nurse of alleged abuse.</p> <p>Resident #5 was admitted to the facility on May 8, 1998, with diagnosis of Seizures, Mental Retardation, Psychosis with Depression and Anxiety. Medical record review of the Minimum Data Set dated June 2, 2010, revealed the resident had both short and long term memory deficits and the resident's cognitive status was "moderately impaired." Further review revealed the resident was totally dependent in bathing.</p> <p>Record review of the facility's statement from LPN (licensed practical nurse) #3 dated May 26, 2010, revealed " ...she had heard a rumor from a CNA that there was a video on a cell phone of resident #5 in the whirlpool tub. LPN #3 stated she did not remember who had told her about it, but stated that she thought she had heard about it sometime during the weekend prior to today ..."</p> <p>Interview with LPN #3 on June 24, 2010, at 10:00 a.m., by phone, revealed she could not recall the specific date she was informed of the existence of the cell phone video of resident #5. Stated she did not report it immediately to the Director of Nurses (DON) because she was told the CNA supervisor was aware of the video. Stated she informed the DON "a couple of days after she found out about the video." LPN #3 stated she did consider the cell phone video as resident abuse and she did not follow policy to report the</p>	F 226			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445292	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/24/2010
NAME OF PROVIDER OR SUPPLIER BEECH TREE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 240 HOSPITAL LANE, PO BOX 300 JELICO, TN 37762		
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F 226	<p>Continued From page 11</p> <p>abuse immediately to the DON or administration.</p> <p>Record review of the facility's statement from CNA #6 dated May 28, 2010, revealed " ...sometime within the past couple of months, she had seen a video taped recording on a cell phone of resident #5 in the whirlpool tub. She did not remember whose phone it was or who else had seen the video." Interview with CNA #6 on June 21, 2010, at 3:15 p.m., in the conference room, revealed she saw the cell phone video of resident #5. She stated she could see the resident, however she could not see any other "body parts." She stated she could not remember when she saw the video. CNA #6 stated she did not report the existence of the cell phone video to her supervisor. Stated "I don't know why I didn't report it." Stated she did not follow the facility's policy on reporting abuse.</p> <p>Record review of the facility's statement from CNA #4 dated May 28, 2010, at 4:00 p.m., revealed "I took a video of ...(resident #5) in the whirlpool..."</p> <p>Review of the facility's "Personal Electronic Devices" policy revealed " ...the use of personal electronic devices is allowed only in designated employee break areas or personal vehicles ...the use of camera functions and/or other audio or video recording functions commonly found on personal electronic devices is not allowed at any time on company property. The use of such functions will be considered a violation of employees and resident privacy ..."</p> <p>Review of the facility's "Abuse Policy" revealed " ...Any alleged violations involving mistreatment, neglect, or abuse ...must be reported to the</p>	F 226			

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F 226	Continued From page 12 administrator or Director of Nursing Services immediately ...The person observing an incident of abuse or suspecting abuse must immediately report such incidents to the charge nurse and the Administrator or Director of Nursing ..." Interview with the Administrator on June 21, 2010, at 11:30 a.m., revealed the facility did not have any system in place to monitor possible violation of cell phone policy by employees. Interview with the DON on June 23, 2010, at 2:15 p.m., confirmed allegations of abuse were not reported immediately to administration. Complaint #TN00025919, #TN00025252	F 226			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431			

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F 431	Continued From page 13 In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to secure medications for one resident (#9) of fourteen residents reviewed. The findings included: Resident #9 was admitted to the facility on December 6, 2006, with diagnoses including Falls Malnutrition, and Hypertension. Medical record review of the Minimum Data Set dated March 11, 2010, revealed the resident had long and short term memory impairment and was modified independent for daily decision making skills.	F 431	F 431 Resident #9 will receive medications in a secure manner and medications will not be left at bedside. Residents will receive medications in accordance with State and Federal laws and currently accepted professional principles and standards including, but not limited to, no medications left unattended at residents' bedside. All licensed nurses will be inserviced by the Assistant Director of Nursing on proper medication pass, including not leaving medications at bedside. Random medication pass audits will be performed by the Assistant Director of Nursing or the facility's pharmacy nurse consultant weekly for four (4) weeks, then PRN to monitor medications remaining secure and not left unattended at bedside. Results of audits will be presented by the Director of Nursing and discussed in the monthly Quality Assurance Committee meeting which is typically attended by the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, MDS/Care Plan Nurse, Social Worker, Activity Director, Dietary Manager, and other administrative staff members.		7/17/10

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F 431	<p>Continued From page 14</p> <p>Medical record review of the Physician's order dated May 17, 2010, revealed "Hold a.m. meds R/T (related to) cup of meds (medications) found at BS (bed side) ..."</p> <p>Telephone interview with RN #2 on June 23, 2010 at 3:00 p.m. confirmed on May 17, 2010, CNA #8 came out of the resident's room with a cup full of medications. Continued interview confirmed RN #2 was in the process of medication pass, but had not prepared the medications for resident #9. Further interview confirmed the medication cup had the resident's name on it, the Physician and the Director of Nursing were notified, and the a.m. medications were held.</p> <p>Interview CNA(Certified Nursing Assistant) #8 on June 24, 2010, in the conference room confirmed on May 17, 2010, upon entering the resident's room the resident had a cup of medications in hand and some medications were noted on the floor. Continued interview confirmed CNA #8 took the cup of medications from the resident and picked up the medications on the floor and reported this to Register Nurse #2.</p> <p>Interview with the Director of Nursing on June 23, 2010, confirmed the above findings, and medications are to be secured and not left unattended at the bedside.</p> <p>c/o TN00025361</p>	F 431			

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